Applicant's Contact Information

Full Name	
Address	
City, State, and Zip Code	
Home Phone	
Cell Phone	
Date of Birth	

List other people living at this address	Age:	Relationship to you:	Employer:

What amount of financial assistance are you requesting? $ _____

Briefly state how this financial assistance will be used if it is granted.

_____

_____

_____

_____

Have you requested financial assistance from any other agency regarding this need? _____

_____

_____

_____

Health Information: Please have your physician fax a note confirming your diagnosis of M.S. to us at fax # 812-423-5650.

Date of M.S. diagnosis (year is fine):	
Current Neurologist's Name:	
Neurologist's Office Phone Number:	
Current Family Doctor/Primary Care:	
Family Doctor's Office Phone Number:	
Name of health insurance:	

Income Information

Employer (if applicable)	
How many hours per week do you work?	
What is your typical income?	$ every

Benefits Information

Do you receive social security disability?	$ per month
Do you receive SSI?	$ per month
Are you eligible for VA benefits?	
Do you have a state medicaid/medical card?	
Do you draw a pension?	$
Do you receive child support payments?	$
Do you have any other source of income? List here.	

Medical Bills: List only those medical bills for the person with M.S. and only the bills that are M.S. related.

Medical Provider	**Amount Owed**

Expenses and Debts

Expenses and Debts Here	**Amount per Month**
Mortgage or Rent (circle one)	$
Home Insurance	$
Automobile Payment	$
Auto Insurance	$
Fuel Costs on Average	$
Health Insurance premium	$
Utilities on Average	$
Medication Costs on Average	$
Grocery Costs on Average	$
Home Telephone	$
Cell Phone	$
Cable	$
Internet	$
Child Support you are required to pay	$
Credit Card Debt	$
	$
	$

By signing below, I certify that the facts contained in this application are true and complete to the best of my knowledge. I authorize verification of all statements contained herein and give permission for the Tri-State M.S. Association to contact parties listed on this application. I realize that failure to disclose requested information may result in denial of request for assistance.

Signature: _____ Date: _____

Submit application to the Tri-State M.S. Association at 971 C South Kenmore Drive, Evansville, IN, 47714 or fax to 812-423-5650. All applicants are required to have a physician fax a statement confirming the diagnosis of M.S. Please call us if you have any questions about this application. Our office number is 812-423-5943/1-866-514-4312.